Annexure - I

Restricted Antibiotics

1. Piperacilin/tazobactam
2. Meropenem
3. Teicoplanin
4. Ticarcillin
5. Vancomycin
6. Aztreonam
7. Colistin
8. Faropenem
9. Fosfomycin
10. Polymyxin B
11. Tigecycline
12. Linezolid
13. Imipenem

Annexure - II

Annex V: Sample pre-authorization/restricted prescribing form

Date:_____

Patient information		OHID!
Patient name:	Department:	Ward:
Age:	Sex: Male ☐ Female ☐	Allergies:

Indication for antibiotic treatment

Request for pre-authorized/restricted antibiotics

Antibiotic(s) requested	Dose and duration	Administration route	Interval	Reason for request

Are microbiology test results with sensitivity testing available? Yes ☐ No ☐
If yes, provide details:

Date	Specimen	Pathogen identified and susceptibility results

Has the patient already received antibiotic(s)? Yes ☐ No ☐ If yes, what?

Antibiotic(s) prescribed	Dose and duration	Administration route	Interval	Why is the treatment not adequate?

Requesting physician's name/contact number:_____

Comments from the AMS team/Drug and therapeutics committee/Pharmacy department

Approver	
☐ APPROVED	☐ NOT APPROVED
Remarks: Name/signature of specialist:_____ Date:_____	